

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 12859					
1. DECEASED NAME (TYPE OR PRINT) <b>Aldon M. Asherman</b>						2a. DATE OF DEATH MONTH <b>5</b> DAY <b>22</b> YEAR <b>1982</b>		2b. HOUR <b>700 P</b>		2c. DATE OF DEATH MONTH <b>5</b> DAY <b>22</b> YEAR <b>1982</b>		2d. HOUR <b>800 P</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>22</b> YEAR <b>1922</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>60</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b> SEC <b>0</b>		7c. DATE OF DEATH MONTH <b>5</b> DAY <b>22</b> YEAR <b>1982</b>		7d. HOUR <b>800 P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>A.T.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>			
10. CITY OR TOWN OF DEATH <b>North East</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hance's Point Yacht Club</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>PA</b>				13b. COUNTY <b>Reading</b>				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS <b>4122 Danor Drive</b>			
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>H.</b> LAST <b>Asherman</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Blodys</b> MIDDLE <b>Goodwin</b> LAST <b>Goodwin</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>004-16-6187</b>		17. INFORMANT <b>Janet White</b>				ADDRESS <b>Danor Dr. Pa.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Hypertension</b>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>Juan C. Gonzalez-Vitale</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>5/22/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Juan C Gonzalez-Vitale MD</b>				ADDRESS <b>Union Hospital, Elkton MD 21921</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>MAY 25, 1982</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St. Philip</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Garrison, Annapolis N.Y.</b>			
24. FUNERAL DIRECTOR NAME <b>259 E Main St. Elkton, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 26 1982</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

15931 15932 15933

15934 15935 15936 15937 15938 15939 15940 15941 15942 15943 15944 15945 15946 15947 15948 15949 15950 15951 15952 15953 15954 15955 15956 15957 15958 15959 15960 15961 15962 15963 15964 15965 15966 15967 15968 15969 15970 15971 15972 15973 15974 15975 15976 15977 15978 15979 15980 15981 15982 15983 15984 15985 15986 15987 15988 15989 15990 15991 15992 15993 15994 15995 15996 15997 15998 15999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 4.

BP

DHMH-16 20M  
(VRA 15, 4) 7/78FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

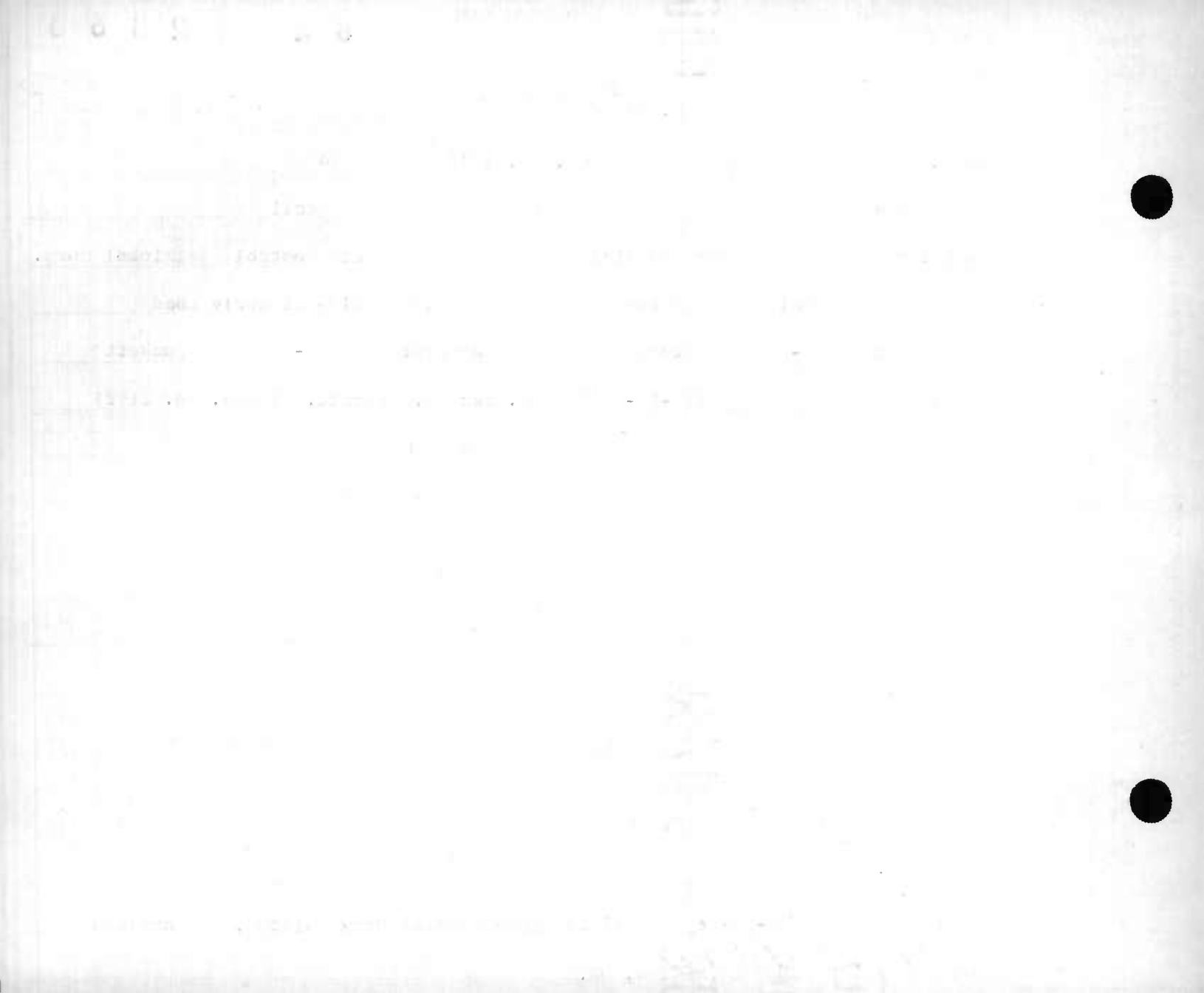
8 2

1 2 3 6 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Genevieve S. Barrett</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5/16/82</i>			2b. HOUR <i>4:25 P</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>OCT. 8, 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.			
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Data Control</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Thiokol Corp.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Elkton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert - Stump</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret - Puckett</i>			16. STREET ADDRESS <i>3159 Singlerly Road</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>219-18-8017</i>		17. INFORMANT ADDRESS <i>Mr. Jack C. Barrett, Elkton, Md. 21921</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Liver Metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5/16 1982</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/12</i> , 19 <i>82</i> , to <i>5/16</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>5/16</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Yogish A. Patel</i>						DEGREE <i>MD</i>		22c. DATE SIGNED <i>5/17/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Yogish A. Patel MD</i>						22e. ADDRESS <i>NEWARK DEl</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>5-19-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gilpin Manor Memorial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Elkton, Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Ralph E. Hicks</i> ADDRESS <i>HICKS HOME FOR FUNERALS, ELKTON, MD.</i>						25a. DATE REC'D. BY REGISTRAR <i>MAY 26 1982</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 2 1 2 8 6 1**  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR May 9, 1982		2b. HOUR 4:15A.M.	
1. DECEASED NAME FIRST MIDDLE LAST JAMES A. BENDER		3. SEX Male		4. RACE White	
5. DATE OF BIRTH MONTH DAY YEAR June 27 1900		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County, MD.		10. CITY OR TOWN OF DEATH Elkton	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 275 Providence Rd. Elkton, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck driver		12b. KIND OF BUSINESS OR INDUSTRY Hauling	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton	
14. FATHER'S NAME FIRST MIDDLE LAST Albert BENDER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta L. Duffield		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 235 - 14 - 6667		17. INFORMANT ADDRESS Mrs. Marie Jones, 275 Providence Rd., Elkton		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory &amp; Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute M.I.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe C.O.P.D.</u> 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (GIVEN IN PART 1): <u>G.A.S. with A.S.C.V.D.; Pulmonary Embolism, Semility</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (the hospital) attended the deceased from <u>Nov. 8</u> , 19 <u>77</u> , to <u>MAY 9</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>MAY 7</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		22b. SIGNATURE <u>Luis M. Cuza</u>	
22c. DATE SIGNED 5-10-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luis M. Cuza, M.D.		22e. ADDRESS 322 East Cecil Avenue, North East, Md. 21901	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 12, 1982		23c. NAME OF CEMETERY OR CREMATORY Richwood Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Richwood, W. Va.		24. FUNERAL DIRECTOR <u>Elkton E. Hicks</u>		25a. DATE REC'D. BY REGISTRAR MAY 14 1982	
25b. REGISTRAR'S SIGNATURE <u>James G. [Signature]</u>		25c. ADDRESS Elkton, Maryland		25d. ADDRESS	

1 5 0 0 1

DATE: MAY 10, 1963

TO: THE DIRECTOR, FBI

FROM: SAC, NEW YORK (100-158711)

SUBJECT: JAMES EARL RAY, AKA; ALLEGED ATTEMPT TO OBTAIN PASSPORT

RE: NEW YORK TELETYPE TO BUREAU, MAY 9, 1963

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE MATTER:

ON MAY 8, 1963, JAMES EARL RAY, AKA, ADVISED THAT HE HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERED HIM \$10,000 TO ASSIST HIM IN OBTAINING A PASSPORT.

RAY STATED THAT HE HAD REFUSED THE OFFER AND WANTED TO REPORT THE MATTER TO THE FBI.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM THE MONEY IN ORDER TO ASSIST HIM IN OBTAINING A PASSPORT TO TRAVEL TO A COUNTRY IN SOUTH AMERICA.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM THE MONEY IN ORDER TO ASSIST HIM IN OBTAINING A PASSPORT TO TRAVEL TO A COUNTRY IN SOUTH AMERICA.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM THE MONEY IN ORDER TO ASSIST HIM IN OBTAINING A PASSPORT TO TRAVEL TO A COUNTRY IN SOUTH AMERICA.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM THE MONEY IN ORDER TO ASSIST HIM IN OBTAINING A PASSPORT TO TRAVEL TO A COUNTRY IN SOUTH AMERICA.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM THE MONEY IN ORDER TO ASSIST HIM IN OBTAINING A PASSPORT TO TRAVEL TO A COUNTRY IN SOUTH AMERICA.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM THE MONEY IN ORDER TO ASSIST HIM IN OBTAINING A PASSPORT TO TRAVEL TO A COUNTRY IN SOUTH AMERICA.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM THE MONEY IN ORDER TO ASSIST HIM IN OBTAINING A PASSPORT TO TRAVEL TO A COUNTRY IN SOUTH AMERICA.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM THE MONEY IN ORDER TO ASSIST HIM IN OBTAINING A PASSPORT TO TRAVEL TO A COUNTRY IN SOUTH AMERICA.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM THE MONEY IN ORDER TO ASSIST HIM IN OBTAINING A PASSPORT TO TRAVEL TO A COUNTRY IN SOUTH AMERICA.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL OFFERED HIM THE MONEY IN ORDER TO ASSIST HIM IN OBTAINING A PASSPORT TO TRAVEL TO A COUNTRY IN SOUTH AMERICA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 2 8 6 2			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
GLENN ESTEN BOLINGER				MAY 10, 1982				4:00 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS	
MALE		CAUC.		FEB. 26, 1920		62 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNA.		U.S.A.				CECIL MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
HACKS POINT		16 3rd St.				OPERATING ENGIN.		CONSTRUCTION			
13a. STATE				13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
MARYLAND				CECIL		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16 3rd St			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FRANK BOLINGER				PEARL EVANS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)		17. INFORMANT ADDRESS							
YES		KOREAN		173-14-0635				DORIS BOLINGER wife same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Severe ASHD DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) sudden death syndrome (found dead in bed)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the deceased) attended the deceased from Aug 1980, 19, to 10 May 82, 19, that (I) (we) last saw the deceased alive on 10 May 82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.											
22b. SIGNATURE Wallace Obenshain MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-11-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WALLACE OBENSHAIN				22e. ADDRESS CECIL*KENT HEALTH SERVICES Cecilton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
BURIAL		5-13-82		GRACELAWN MEM, PK				WILMINGTON, N.C. COUNTY DEL. STATE			
24. FUNERAL DIRECTOR NAME EDW. FELLOWS AND SON CECILTON, MD 21913				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
				MAY 13 1982				James Santhorn			

BP

30851 18

2-2

CH 1

COLE BROOKS

(Red at 10:00 AM) ...

30851

(Red at 10:00 AM)

SH 1001

30851

... ..



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
I. DECEASED NAME (TYPE OR PRINT) Everett LeRoy Bowen		2a. DATE OF DEATH MONTH DAY YEAR May 24, 1982	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 3 1888	6. AGE (IN YEARS LAST BIRTHDAY) 94 yrs. #YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.
10. CITY OR TOWN OF DEATH Rising Sun	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Hills, Mill Pond Dr., (Home)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer	12b. KIND OF BUSINESS OR INDUSTRY St. Roads Comm.
13a. STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Rising Sun	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Abraham G. Bowen	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jones	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W. II	
16b. SOCIAL SECURITY NO. 220-36-9224		17. INFORMANT ADDRESS Everett G. Jackson Bon Air Farm Rising Sun, Md. 21911	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Decompensation</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. 2 wks.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6-1</u> 19 <u>70</u> to <u>5-24</u> 19 <u>82</u> that (I) (we) lost saw the deceased alive on <u>5-24</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Neil R. Taylor, Jr. M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5-25-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil R. Taylor, Jr., M.D.		22e. ADDRESS Haines Avenue & Walnut Rising Sun, Maryland 21911	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 27, 1982	23c. NAME OF CEMETERY OR CREMATORY West Nottingham	23d. LOCATION CITY OR TOWN COUNTY STATE Cecila Cecil Maryland
24. FUNERAL DIRECTOR <u>Lee H. Patterson</u>		25. DATE RECEIVED BY REGISTRAR 5-24-82	
26. ADDRESS Baltimore, Maryland		27. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 2 1 2 8 6 4	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William Walter Case</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 11, 1982</i>		2b. HOUR <i>3:37</i> P M
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 24, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Delaware</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.	
10. CITY OR TOWN OF DEATH <i>Elkton</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Inspector</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Automotive</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Cecil</i> 13c. CITY OR TOWN <i>Elkton</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>117 Osage Street</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Walter Case</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillie Marker</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <i>WWII 221-12-5859</i>	17. INFORMANT ADDRESS <i>Rebecca Case 117 Osage St. Elkton, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Infarction.</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>generalized atherosclerotic vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <i>4/22</i> 19 <i>75</i> , to <i>5/11</i> 19 <i>82</i> , that (II) (we) last saw the deceased alive on <i>5/11</i> 19 <i>82</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(we)</i> <i>(did not)</i> view the body after death.					
22b. SIGNATURE <i>Jui-Chih Hsu</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>5/12/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jui-Chih Hsu, MD.</i>		22e. ADDRESS <i>223 W. Main St. Elkton, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>May 15, 1982</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gilpin Manor Mem. Pk. Cecil</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Elkton Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Edward M. McKim</i> ADDRESS <i>259 E. Main St. Elkton, Md.</i>		25a. DATE RECD. BY REGISTRAR <i>MAY 14 1982</i>			

BP

37

1911

1911

1911

1911

1911

1911

1911

Call

Call

Call

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/73  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
Joseph A. Charbonneau		May 25, 1982		8 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	45 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Massachusetts	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Cecil MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital		Truck Driver		Haulmark Trans.
13a. STATE		13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS		
Delaware	13c. CITY OR TOWN	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	24 Opus Drive		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Joseph A. Charbonneau		Edith E. Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		011-26-5972		Mrs. Ruth V. Charbonneau, Newark, Del. 19702	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIAC ARREST					
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSIS					
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1981, 19 to 5/25/82, 19, that (I) (we) last saw the deceased alive on 5/25/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Phillip Pollner MD				5/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Phillip Pollner MD		Elkton Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		5-28-82	Gracelawn Memorial Park, Wilmington, Delaware		
24. FUNERAL DIRECTOR NAME		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ralph E. Hicks		JUN 3 1982		Name Jan	
HICKS HOME for FUNERALS, ELKTON, MD.					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 2 8 6 6			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Ada Elizabeth Cheadle				May 16, 1982			
3. SEX				4. RACE			
Female				White			
5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
Sept. 9 1894				87			
7. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY)				8. CITIZEN OF WHAT COUNTRY?			
Maryland				U.S.A.			
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				10. BALTIMORE CITY OR COUNTY OF DEATH			
				Cecil MD.			
11. CITY OR TOWN OF DEATH				12. USUAL OCCUPATION			
North East				Housewife			
13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				14. KIND OF BUSINESS OR INDUSTRY			
638 Irishtown Rd.				Home			
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				16. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Md. Cecil North East				638 Irishtown Rd.			
17. FATHER'S NAME				18. MOTHER'S MAIDEN NAME			
17a. FIRST MIDDLE LAST				17b. FIRST MIDDLE LAST			
Joseph A. George				Camillia Jane Bristow			
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				20. SOCIAL SECURITY NO.			
No				218-54-2811			
21. INFORMANT				22. ADDRESS			
Lee A. Cheadle North East, Md. 21901				638 Irishtown Rd.			
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Cardiac & Respiratory Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4151							
DUE TO, OR AS A CONSEQUENCE OF (b). Acute MI & CHF							
DUE TO, OR AS A CONSEQUENCE OF (c). Pulmonary Infarction							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Chronic Bronchitis, Arteritis, Sensitivity, Malnutrition							
24. DATE OF OPERATION				25. CONDITION FOR WHICH OPERATION WAS PERFORMED			
26. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				27. TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
28. INJURY OCCURRED				29. PLACE OF INJURY			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			
30. LOCATION				31. CITY OR TOWN			
				CITY OR TOWN COUNTY STATE			
32. I certify that (I) (the deceased) attended the deceased from 4-16-19-82, to May 16 19-82, that (I) (the deceased) saw the deceased alive on 5-14-19-82, and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (the) did not view the body after death.				33. DATE SIGNED			
34. SIGNATURE				35. DEGREE			
Luis M. Cuza				MD			
36. PHYSICIAN'S NAME (TYPE OR PRINT)				37. ADDRESS			
Luis M. Cuza, M.D.				322E Cecil Ave. North East Md 21901			
38. BURIAL, CREMATION, REMOVAL (SPECIFY)				39. DATE			
Burial				5-19-82			
40. NAME OF CEMETERY OR CREMATORY				41. LOCATION			
North East Meth.				North-East Cecil Md.			
42. FUNERAL DIRECTOR				43. DATE REC'D BY REGISTRAR			
Paul R. Bouch				MAY 18 1982			
44. ADDRESS				45. REGISTRAR'S SIGNATURE			
North East, Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8-2  
CERTIFICATE OF DEATH

1 2 8 6 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FLORENCE MAY COOPER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 5, 1982</b>			2b. HOUR <b>3:40 A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 28, 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Perry Point</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, Perry Point, Maryland</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse-Nursing</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3100 St. Paul St., # 510</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Cooper</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Louise Cattell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			16b. SOCIAL SECURITY NO. <b>WW I 218 26 9529</b>		17. INFORMANT ADDRESS <b>Herbert R. Smith, Jr. Deerfield, Fla. 33441</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7-9-19-81</b> , to <b>5-5-19-82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5-5-19-82</b> , and that in <b>xx</b> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <del>not</del> view the body after death.									
22b. SIGNATURE <b>Prem Laluni</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>5-5-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PREM LAL, M.D.</b>					22e. ADDRESS <b>VAMC, Perry Point, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Washington Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Plymouth Meeting, Pa.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>JENKINS FUNERAL HOME Baltimore, MD</b>					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>MAY 10 1982 [Signature]</b>		

BP  
DHMH-16 50M 1/81  
(VRA 15, 4)

JEKINS FUNERAL HOME Baltimore, MD

405 York Road - 1212

Card 1

Edwards Geo. Washington Mrs. - Buried in Section 12

PRIME LAND, S.D.

VALE, Perry Point, Maryland

XXXX

2-3-82

1-8-81

3-3-82

82

3-3-82

Immunization

Respiratory Failure

Yes

WW I

210 25 9330

VALE, Perry Point, Maryland

Water

Doc. No.

Louis

Cecil

Section 12

Perry Point

VALE, Perry Point, Maryland

Section 12

to Perry

U. A.

Oil Canal

Min.

1-2-81

Florence J. Corboy

EBP

May 3, 1962

3542

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

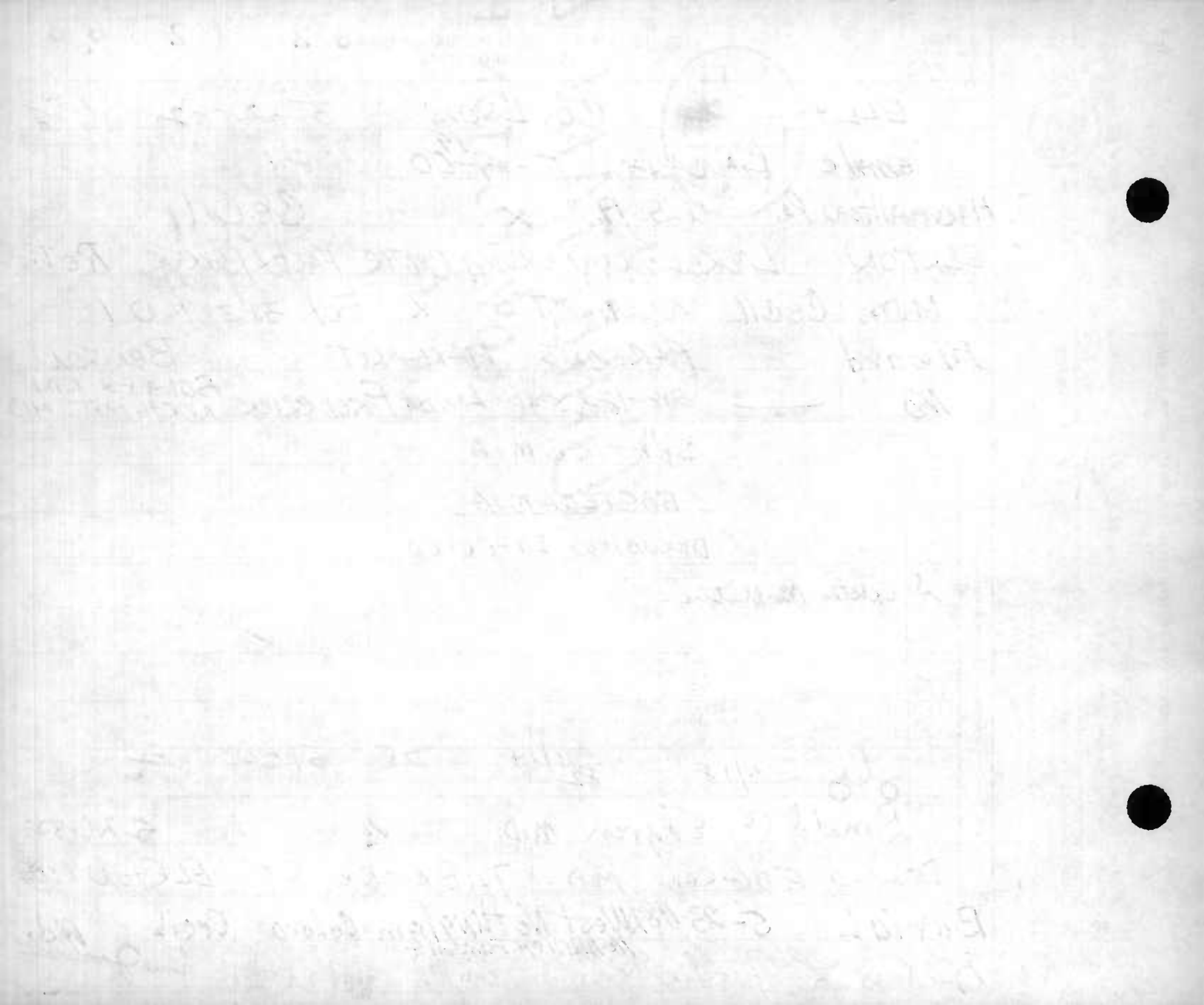
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 2 8 6 8	
1. FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLA COULSON			2a. DATE OF DEATH MONTH DAY YEAR 5-20-82		2b. HOUR 6:30 AM
3. SEX Female	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 5-29-00	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARSHALLTON PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAKEWOOD NURSING Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FACTORY WORKER	12b. KIND OF BUSINESS OR INDUSTRY Ret.	
13a. STATE MD.			13b. COUNTY Cecil	13c. CITY OR TOWN NORTH EAST	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edward PARSONS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET BENSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF NOT UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-18-2848	17. INFORMANT ADDRESS LINDA FREDERICK BOX 383 RD 1 NORTH EAST MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 2507 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) BACTEREMIA (c) DECUBITUS, INFECTED					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dysenteria					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 11/14 1978, to 5/20 1982, that (1) (we) lost (above) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald C. Edgren M.D.		DEGREE M.D.		22c. DATE SIGNED 5-20-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD EDGREN M.D.		22e. ADDRESS 721 BRIDGE ST. ELKTON MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-23-1982		23c. NAME OF CEMETERY OR CREMATORY West Nottingham	
24. FUNERAL DIRECTOR NAME Richard L. Goodie		24b. ADDRESS Rising Sun, MD.		25. REGISTERAR'S SIGNATURE Name	
25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE Name			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR 415 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 12369					
1. DECEASED NAME FIRST MIDDLE LAST Kathleen W. Deshane										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 15 1982		2b. HOUR 6:00 P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 24 08		6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 15 1982		7d. HOUR 7:00 P M	
1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH CECIL			
10. CITY OR TOWN OF DEATH Elkton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurelwood Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET CLERK				12b. KIND OF BUSINESS OR INDUSTRY FOOD			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE MD		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 100 Laurel Drive							
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM DE SHANE										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE WALTERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-18-3593		17. INFORMANT ADDRESS Penelope H. Brasher, Director of Nursing									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9110 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Obstruction of upper respiratory tract by foreign body (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Aspiration of a fragment of meat									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE J. C. Gonzalez-Vitale				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 5/15/82							
EXAMINER'S NAME (TYPE OR PRINT) Juan C. Gonzalez-Vitale, MD				ADDRESS Union Hospital, Elkton, MD 21921											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5-19-82		23c. NAME OF CEMETERY OR CREMATORY BETHEL				23d. LOCATION CITY OR TOWN COUNTY STATE CHESAPEAKE CITY CECK MD					
24. FUNERAL DIRECTOR NAME J. T. FAIR				ADDRESS FOUR FUNERAL HOME MD				25a. DATE REC'D. BY REGISTRAR MAY 18 1982		25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

15001



NOV 10 1960



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Patrick			MIDDLE J.			LAST Endres			20. DATE KNOWN OF DEATH ESTIMATED			<input checked="" type="checkbox"/> MONTH 5			DAY 15			YEAR 1982			2b. HOUR M 3:15 P		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 11-16-18			6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 15 1982			2d. HOUR M 3:15 P								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.																	
10. CITY OR TOWN OF DEATH Earleville			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 235 White Crystal Beach Rd															12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PIPE FINDER			12b. KIND OF BUSINESS OR INDUSTRY Shipyard					
13a. STATE MD			13b. COUNTY Cecil			13c. CITY OR TOWN Earleville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 235 White Crystal Beach Rd														
14. FATHER'S NAME FIRST MIDDLE LAST Anthony ENDRES									15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McEvoy																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES						16b. SOCIAL SECURITY NO. 173-85-5014						17. INFORMANT ADDRESS Mabel E. Reynolds (Address as above)														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes mellitus																										
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																										
ACTUAL SIGNATURE John C. Gonzalez-Vitali, MD						TITLE (SPECIFY) Deputy						DATE SIGNED 5/15/82														
EXAMINER'S NAME (TYPE OR PRINT) John C. Gonzalez-Vitali, MD						ADDRESS Union Hospital, Elkton, MD																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						23b. DATE 5-18-82						23c. NAME OF CEMETERY OR CREMATORY STS. PETER & PAUL						23d. LOCATION CITY OR TOWN COUNTY STATE S Del. P.H.								
24. FUNERAL DIRECTOR NAME EDW. Fellows + Son						ADDRESS CECILTON MD 21913						25a. DATE REC'D. BY REGISTRAR MAY 24 1982						25b. REGISTRAR'S SIGNATURE James Van Kesteren								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for advice.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 2 8 7 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE D. ETZLER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>May 14, 1982</b>		2b. HOUR <b>6:20pm</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-22-20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b> 13c. CITY OR TOWN <b>Cecil</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>House De Grace</b>		13f. STREET ADDRESS <b>739 Earleton Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY Etzler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kathryn Day</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>219-07-9896</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest-acute pulmonary edema</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic coronary disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Cancer of pancreas w/wide spread metastasis and massive ascites</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <b>XX</b> (this hospital) attended the deceased from <b>May 11,</b> 19 <b>82</b> , to <b>May 14</b> , 19 <b>82</b> . <b>XXXXXXXXXX</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (I) (did) (did not) view the body after death.							
22b. SIGNATURE <b>K. H. Huebner</b> DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>5-18-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. H. HUEBNER, M.D.</b>				22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-21-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sylmarith Carroll Md.</b>	
24. FUNERAL DIRECTOR (NAME) <b>Haight Funeral Home, Sykesville, Md.</b>				25. DATE REC'D. BY REGISTRAR 25f. REGISTRAR'S SIGNATURE <b>MAY 19 1982</b>			

0:00pm

May 14, 1968

ENTER

D.

RECEIVED

VA Medical Center

Forty Fort, Md.

20-07-0000

Cervical intra-uterine adenoma

Antihistaminic economy disease

Cancer of pancreas which spread metastatic and massive ascites

X

XXXXXXXX

00

May 14

00

May 14

XX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

00-10-00

XX

X

VA Medical Center, Forty Fort, Md.

X. H. WERNER, M.D.

Eighty Fourth Ave, Syosville, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

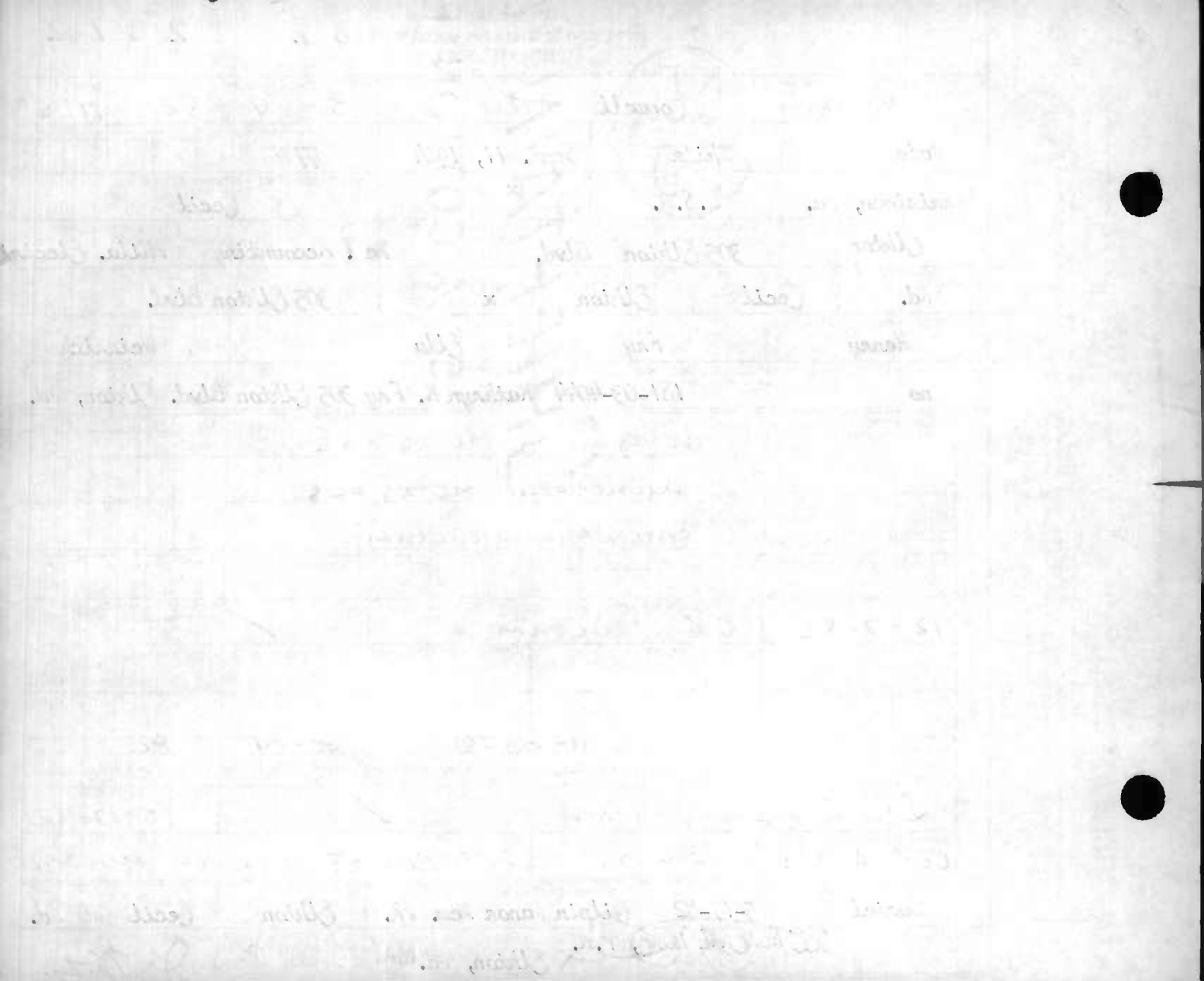
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR 1. STATE REGISTER					8 2 1 2 8 7 2 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
William Cornwell Fry					5-14-82				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
Male		White		Sept. 11, 1904		77 YRS		11:15 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Norristown, Pa.		U.S.A.				Cecil			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		305 Elkton Blvd.				Acctg.		Phila. Electric	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13b. STATE					13c. CITY OR TOWN				
Md.					Elkton				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Henry Fry					Ella Weinrich				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
no					181-03-4044		Kathryn K. Fry 305 Elkton Blvd. Elkton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED METASTASIS</u> <u>1541</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA RECTUM</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
12-7-82			CA RECTUM			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-30-81</u> , 19 <u>81</u> , to <u>5-14</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5-17-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Leo A. Natona</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>5-17-82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
LEO A. NATONA M.D.			206 BOW ST ELKTON MD 21921						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			5-17-82		Gilpin Manor Mem. Pk.		Elkton Cecil Md.		
24. FUNERAL DIRECTOR NAME			24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE				
SEE FUNERAL HOME P.A.			MAY 20 1982		James J. Nathan				

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 2 8 7 3	
1. DECEASED NAME (TYPE OR PRINT) <b>Wade Kessler Goodman</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>May 15 1982</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 19 1910</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>72 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>May 15 1982</b>		2d. HOUR <b>1047 A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ab Co., N. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>					
10. CITY OR TOWN OF DEATH <b>Conowingo</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>266 Old Conowingo Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE <b>Postal Clerk Post Office</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Conowingo</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>266 Old Conowingo Rd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Goodman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dora Johnston</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>4100</b>		17. INFORMANT ADDRESS <b>John Goodman Bel Air, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>J. C. Gonzalez-Vital</b>				TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>5/15/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Juan C Gonzalez-Vital MD</b>				ADDRESS <b>Union Hospital, Elkton, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SICUT) <b>Burial</b>		23b. DATE <b>5-17-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Conowingo Baptist</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Conowingo Cecil MD</b>			
24. FUNERAL DIRECTOR <b>McMullen</b>		ADDRESS <b>Rising Sun</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 18 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

Washington, D.C. 20250

March 10, 1954

Mr. J. H. ...

Dear Sir:

I am very pleased to hear from you and to learn that you are interested in the work of the Bureau of Plant Industry.

The Bureau is currently engaged in a number of projects which are of great importance to the plant industry.

One of the most important of these projects is the study of the diseases of plants.

This study is being carried out in cooperation with the Bureau of Entomology and Plant Quarantine.

The results of this study will be of great value to the plant industry.

I am sure that you will find this work of great interest.

I am very glad to hear that you are interested in the work of the Bureau.

I am sure that you will find this work of great interest.

I am very glad to hear that you are interested in the work of the Bureau.

I am sure that you will find this work of great interest.

I am very glad to hear that you are interested in the work of the Bureau.

I am sure that you will find this work of great interest.

I am very glad to hear that you are interested in the work of the Bureau.

I am sure that you will find this work of great interest.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <i>Marguerite T. Grandfield</i>					2a. DATE OF DEATH MONTH <i>5</i> DAY <i>10</i> YEAR <i>1982</i>				
3 SEX <i>Female</i>					4. RACE <i>White</i>				
5. DATE OF BIRTH MONTH <i>May</i> DAY <i>26</i> YEAR <i>1909</i>					6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>					7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.				
10. CITY OR TOWN OF DEATH <i>Elkton</i>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Salesperson</i>					12b. KIND OF BUSINESS OR INDUSTRY <i>Gimbels, Phila.</i>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Penna.</i> 13b. CITY OR TOWN <i>Philadelphia</i>					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST <i>Robert</i> MIDDLE <i>Hammer</i> LAST <i>Grandfield</i>					15. MOTHER'S MAIDEN NAME FIRST <i>Theresa</i> MIDDLE <i>Gertrude</i> LAST <i>Preston</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>					16b. SOCIAL SECURITY NO. <i>185-10-7095</i>				
17. INFORMANT <i>Mrs. Margaret M. Wilson, Elkton, Md.</i>					ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY HEMORRHAGE</i> 4960 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>DETERIORATING BRONCHOPNEUMONIA</i> (c) <i>SEVERE COPD</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>				
21c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21e. LOCATION STREET CITY OR TOWN COUNTY STATE					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <i>5-3</i> 19 <i>82</i> to <i>5-10</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>5-10</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <i>Glenn A. Gayle</i> DEGREE									
22b. DATE SIGNED <i>5-10-82</i>									
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rolando Majera MD</i>									
22d. ADDRESS <i>Elkton, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>					23b. DATE <i>5-13-82</i>				
23c. NAME OF CEMETERY OR CREMATORY <i>Friends Burial Ground</i>					23d. LOCATION CITY OR TOWN COUNTY STATE <i>Calvert, Maryland</i>				
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i> ADDRESS <i>HICKS HOME FOR FUNERALS, ELKTON, MD.</i>					25a. DATE REC'D. BY REGISTRAR <i>MAY 14 1982</i>				
25b. REGISTRAR'S SIGNATURE <i>Ralph E. Hicks</i>									

U.S. DEPARTMENT OF THE ARMY  
MEDICAL DEPARTMENT  
HISTORICAL RECORDS

NAME	DATE	LOCATION	REMARKS
WILLIAM J. HARRIS	1942-10-10	W. HARRIS, HARRIS, AR.	
WILLIAM J. HARRIS	1942-10-10	W. HARRIS, HARRIS, AR.	
WILLIAM J. HARRIS	1942-10-10	W. HARRIS, HARRIS, AR.	
WILLIAM J. HARRIS	1942-10-10	W. HARRIS, HARRIS, AR.	
WILLIAM J. HARRIS	1942-10-10	W. HARRIS, HARRIS, AR.	
WILLIAM J. HARRIS	1942-10-10	W. HARRIS, HARRIS, AR.	
WILLIAM J. HARRIS	1942-10-10	W. HARRIS, HARRIS, AR.	
WILLIAM J. HARRIS	1942-10-10	W. HARRIS, HARRIS, AR.	
WILLIAM J. HARRIS	1942-10-10	W. HARRIS, HARRIS, AR.	
WILLIAM J. HARRIS	1942-10-10	W. HARRIS, HARRIS, AR.	

WILLIAM J. HARRIS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 2 8 7 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>VIRGIE L. HAMM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 25 82</b>		2b. HOUR <b>11:59 AM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>December 19, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Elkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Elkton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James B. Stike</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret - Stuart</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>221-03-8857</b>		17. INFORMANT ADDRESS <b>Mr. Don R. Farmer, Kennett Square, Pa.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Act Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-3</b> , 19 <b>81</b> , to <b>5-25</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>5-25</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Gayandil K. Paterniti</b> DEGREE				22c. DATE SIGNED <b>5/25/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>123 Singarly Ave</b>				22e. ADDRESS <b>ELKTON MD. 21921</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5-28-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Penn Hill Burying Grounds, Lancaster Co.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pa.</b>
24. FUNERAL DIRECTOR <b>HICKS HOME FOR FUNERALS, ELKTON, MD.</b>		DATE REC'D. BY REGISTRAR <b>JUN 5 1982</b>	
25. REGISTRAR'S SIGNATURE <b>HICKS</b>		26. REGISTRAR'S SIGNATURE <b>HICKS</b>	



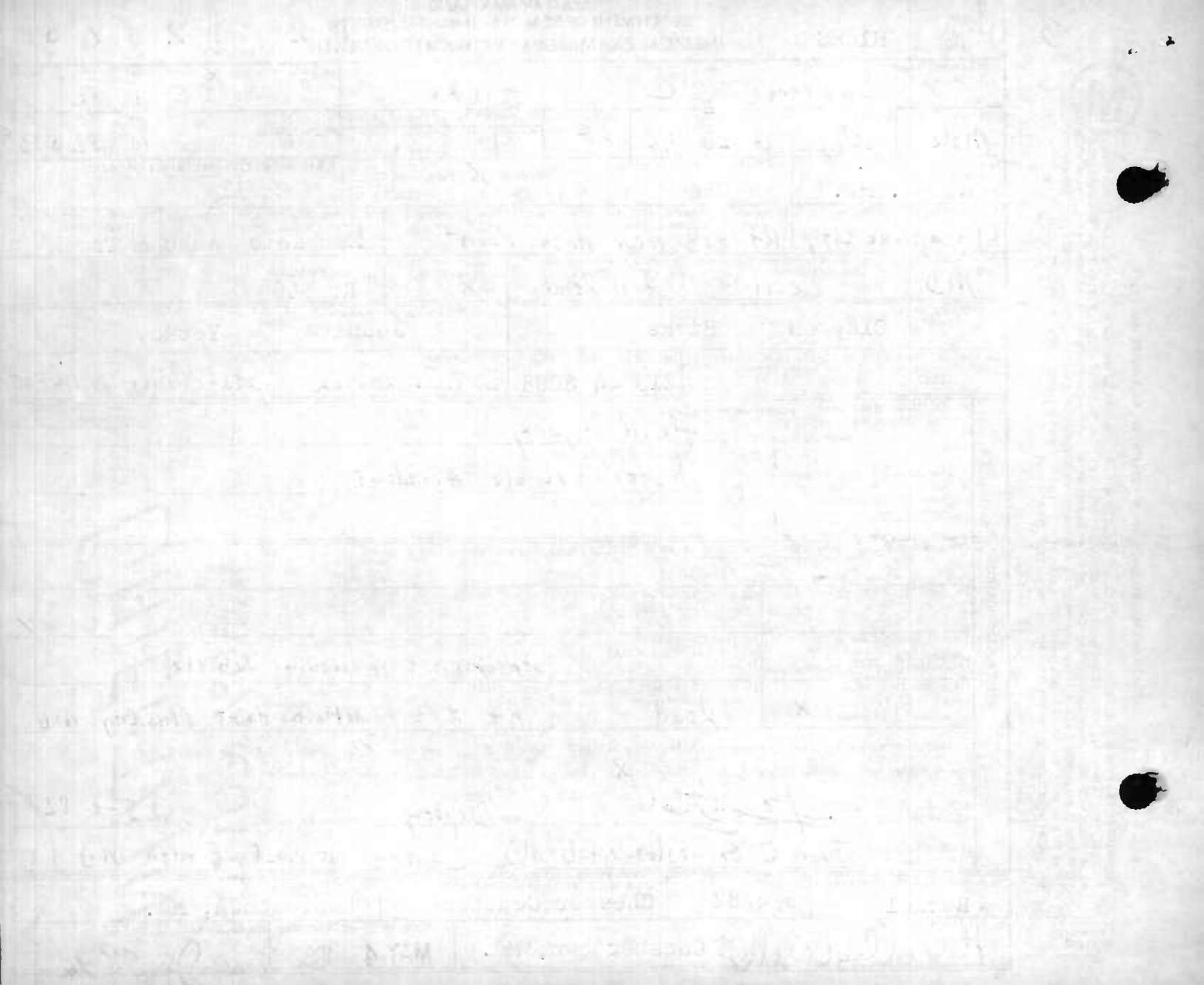
BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR		HICKS		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		STATE OF MARYLAND		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Lawrence		MIDDLE C		LAST Hicks		2a. DATE KNOWN OF DEATH MATED	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7c. DATE PRONOUNCED DEAD	
Male		White		6 17 46		35 YRS.		5 1 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR	
Kent Co. Md.		USA				Cecil		8:33 A.M.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Chesapeake City		Rt 213, near Hacks Point		Mechanics		Auto & Truck			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MD		Cecil		Still Pond				Rt 566	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
FIRST Clayton		MIDDLE Hicks		LAST Hicks		215 44 6088		J.T. Jankowiak State Police, North East	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?			
PART I DEATH WAS CAUSED BY:						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
IMMEDIATE CAUSE (a)		8/18/89		Head injury					
DUE TO, OR AS A CONSEQUENCE OF				Motor Vehicle Accident					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				Thrown out of moving vehicle					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
		Road		Rt 213, near Hacks Point Ches. City, MD					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED			
ACTUAL SIGNATURE		M.D.		MEDICAL EXAMINER		5-1-82			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		MEDICAL EXAMINER		DATE SIGNED			
Juan C Gonzalez-Vital, MD		Union Hospital, Elkton, MD				5-1-82			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY STATE	
Burial		5/4/82		Chester Cemetery		Chestertown, Md.		Chester County Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William Wells		Chestertown, Md.		MAY 4 1982		James J. [Signature]			



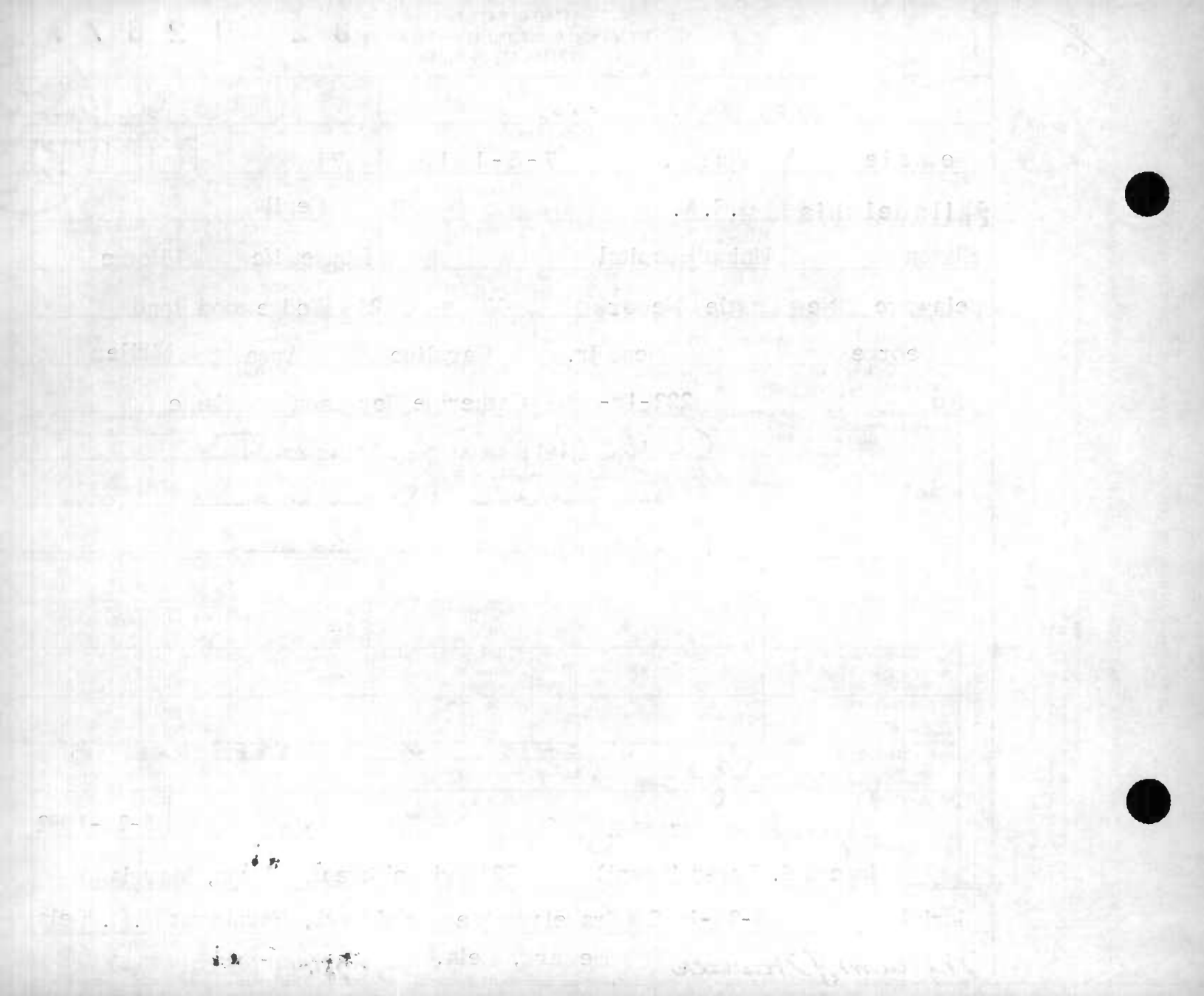
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helen M. Holloft</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>5/23/82</i>		2b. HOUR <i>105 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7-5-1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Philadelphia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.			
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Delaware</i>						13b. COUNTY <i>New Castle</i>		13c. CITY OR TOWN <i>Newark</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Hess Jr.</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Caroline Anna Müller</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>222-16-0601</i>		17. INFORMANT ADDRESS <i>Catherine Ferguson Same</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i> <i>3310</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Aspiration Pneumonia</i> (c) <i>Alzheimer's Disease</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>2-13</i> , 19 <i>81</i> , to <i>5/23</i> , 19 <i>82</i> , that (2) (we) last saw the deceased alive on <i>5/23</i> , 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)									
22b. SIGNATURE <i>Joseph G. Lanzi</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <i>5-24-1982</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph G. Lanzi (Lanzi)</i>						22e. ADDRESS <i>721 Bridge Street, Elkton, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-26-1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gracelawn Memorial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Farnhurst N.C. Dela</i>			
24. FUNERAL DIRECTOR NAME <i>William J. Newark</i> ADDRESS <i>Newark, Dela.</i>						25a. DATE REC'D. BY REGISTRAR <i>MAY 26 1982</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST CLARA KIRK JAMISON			MONTH DAY YEAR MAY 4, 1982			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		
Female	White	MONTH DAY YEAR February 5, 1907	75 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA		Cecil MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Elkton	Union Hospital			Secretary- Suburban Trust Bank				
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
Maryland			Hyattsville			6506 40th Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Edward - Pierson			Emma Jane Green					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			214-28-7741			Mrs. Nancy K. Hockersmith, Hyattsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASHD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <i>6-4-1982</i> to <i>5-4-1982</i> , that (we) last saw the deceased alive on <i>6-4-1982</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If you solid) did not view the body after death.								
22b. SIGNATURE <i>Joseph G. Lanzi</i>						22c. DATE SIGNED 5-6-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph G. Lanzi, M.D.						22e. ADDRESS 721 Bridge Street, Elkton, Md. 21921		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			5-6-82		Cherry Hill Methodist		Cemetery, Cherry Hill, Md.	
24. FUNERAL DIRECTOR NAME <i>Donald S. Hicks</i> ADDRESS						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
HICKS HOME for FUNERALS, ELKTON, MD.						MAY 11 1982		



BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 2 8 7 9	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME				2a. DATE OF DEATH	
FIRST MIDDLE LAST Julian H. Jones				MONTH DAY YEAR 5/24/82	
3. SEX MALE				4. RACE CAUC.	
5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)	
* 8 MONTH DAY YEAR - 31-15				66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.	
10. CITY OR TOWN OF DEATH ELKTON				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL OF CECIL CO.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRIDGETENDER				12b. KIND OF BUSINESS OR INDUSTRY ST. OF MD	
13a. STATE MARYLAND				13b. CITY OR TOWN KENT	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS BOX 144	
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW WOODALL JONES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE HURLOCK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 5-41 9-41 217-09-6470	
17. INFORMANT ADDRESS JULIAN W. JONES son-same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY DISTRESS</u> 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>5-24-82</u> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jo Ann Rosenfeld, MD.				22c. DATE SIGNED 5/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jo Ann Rosenfeld M.D.				22e. ADDRESS Cecilton, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 5-27-82		23c. NAME OF CEMETERY OR CREMATORY CECILTON ZION	
23d. LOCATION CITY OR TOWN COUNTY STATE CECILTON, CECIL, MARYLAND					
24. FUNERAL DIRECTOR NAME EDW. FELLOWS AND SON MILLINGTON, MD 21651				25a. DAY OF REGISTRATION JUN 3 1982	

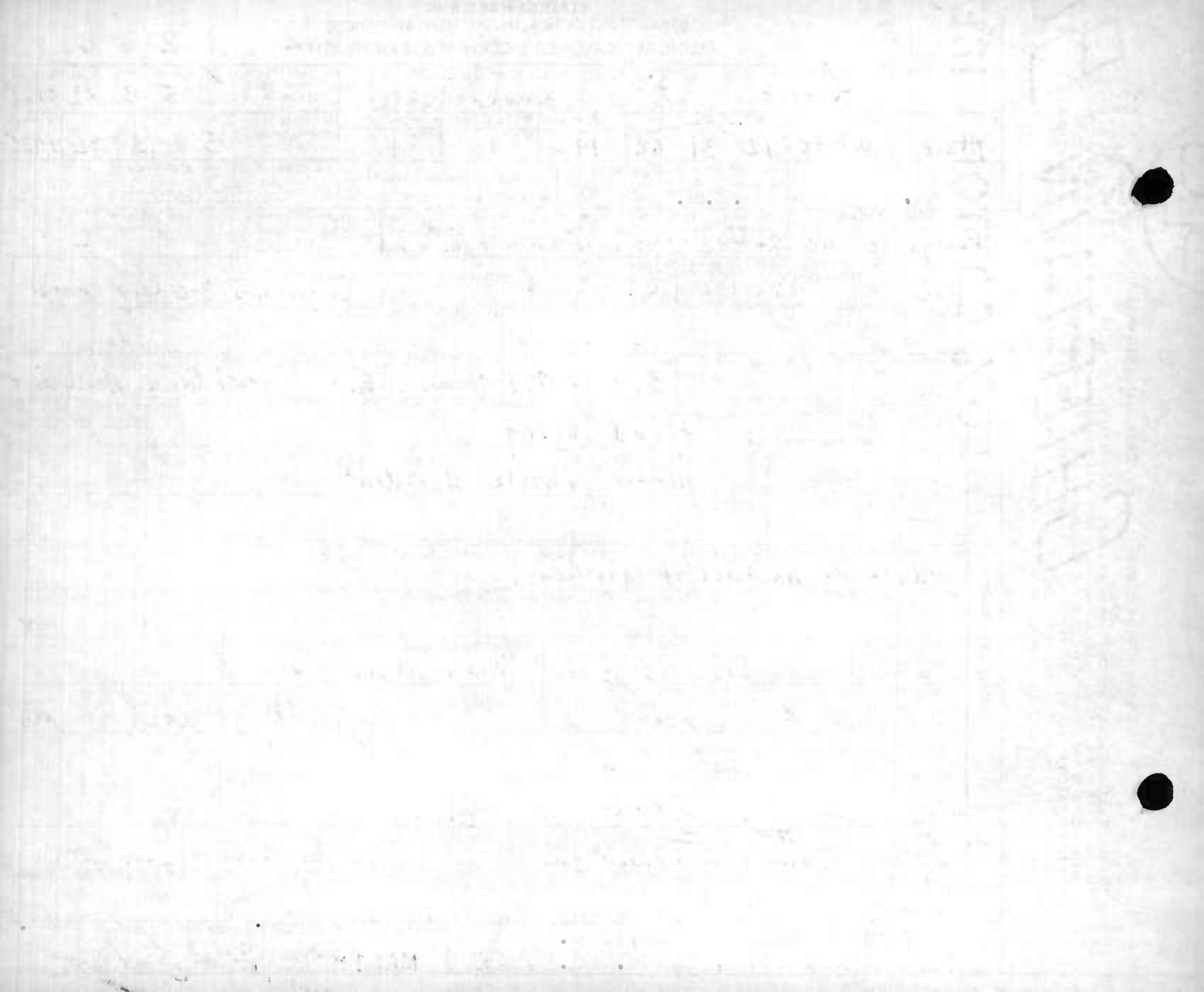
MAILED

NOV 13 1903

NOV 13 1903

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 2 8 8 0					
1. DECEASED NAME (TYPE OR PRINT) Robert Robert						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 13 1982						2b. HOUR 5:16 P M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 31 62		6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 13 1982		2d. HOUR 9:45 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.					
10. CITY OR TOWN OF DEATH Perryville, MD				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 222 2/10 mile south of Church Rd St. Marks								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE MD				13b. COUNTY Cecil				13c. CITY OR TOWN Fort Deposit				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Susquehanna Job Corp Center			
14. FATHER'S NAME FIRST MIDDLE LAST Marion Kiwakowski						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Smith											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no						16b. SOCIAL SECURITY NO. 216-96-7749						17. INFORMATION Marion Kiwakowski, Bel Air, Md. State Police, North East					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head injury 8199 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Motor Vehicle Accident (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Multiple fractures of long bones																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:03 P.M. 5 13 1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Motor vehicle crash									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Perryville Cecil MD									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Deputy								DATE SIGNED					
EXAMINER'S NAME (TYPE OR PRINT) Judn C. Gonzalez-Ditah				ADDRESS Union Hospital, Elkton, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/17/82				23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Jesus Balto.				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Chhimunek Funeral Home, Inc.				ADDRESS 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR MAY 18 1982				25b. REGISTRAR'S SIGNATURE					



Item #6 per phone call w/Fun. Home STATE OF MARYLAND  
FOR 5/20/82 rc DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
1- STATE REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 12881

1. DECEASED NAME (TYPE OR PRINT) <b>Maisie E Kozycki</b>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>5 3 1982</b>			2b. HOUR OF DEATH M <b>4:55 P</b>		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 14 45</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>35 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>5 3 1982</b>	2d. HOUR OF DEATH M <b>7:30 P</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL</b> MD.		
10. CITY OR TOWN OF DEATH <b>CONOWINGO</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt 222 3/10 mile North of Rt 1</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Conowingo</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOE B JONES</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NEILLIE PILLKINGTON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>ALBERT J. KOZYCKI</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Head injury and fracture of cervical spine</b> 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4:55 PM 5 3 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Struck by an automobile</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Road</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt 222 3/10 mile North of Rt 1, Cecil, MD</b>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Juan C Gonzalez-Vital</b>		TITLE (SPECIFY) M.D. <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>5/13/82</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Juan C Gonzalez-Vital, MD</b>		ADDRESS <b>Union Hospital, Elkton, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>		23b. DATE <b>5-6-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BROOKVIEW</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RISING SUN CECIL MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>R.T. FOARD FUNERAL HOME 110</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 10 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 8 2 1 2 8 8 2						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
WALTER W. LAUTENBACH						April 24, 1982			11:23A
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		Cau.		April 6 1899		83 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		USA				Perry Point Cecil Co MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Perry Point		VA Medical Center Perry Point, MD				Retired		Farmer	
13a. STATE			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Virginia			N/A		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		603 King Street 22314		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Unobtainable			Unobtainable						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)		17. INFORMANT ADDRESS				
Yes			1922-1924		Mr. Grabell 603 King Street Alexandria, Va. 22314				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of Lung with Metastases</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>Mar 19</u> , 19 <u>82</u> , to <u>Apr 24</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>Apr 24</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Parasho Hanu</u>								4-25-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
CHANDROTH V. PURUSHOTHAMAN, M.D.			VAMC Perry Point, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		May 10 82		Arlington National Cemetery		Arlington Va.			
24. FUNERAL DIRECTOR NAME			ADDRESS			DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE			
<u>W.B. Sullings</u>			Demaine FH Alex. Va.			MAY 17 1982 <u>Parasho Hanu</u>			

МАТЕРИИ

Canoe at 12:15 and 2:30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 2 8 8 3	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELLIS W. LESIUK</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5 29 82</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 3 23</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>59</b>	
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman - General</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Motors Corp.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael - Lecuk</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna - Bernics</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>219-16-4726</b>		17. INFORMANT ADDRESS <b>Mrs. Annie Mae Lesiuk, Elkton, Md. 21921</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1629 Adeno Carcino of Lung</b> IMMEDIATE CAUSE (a) <b>Adeno Carcino of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>which Extensive</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>metastasis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/28/82</b> , 19____, to <b>5/29/82</b> , 19____, that (I) (we) last saw the deceased alive on <b>5/28/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE DEGREE <b>Jayantilal K. Patel M.D.</b>				22c. DATE SIGNED <b>5/29/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>123 S. GINGERLY AVE ELKTON MD - (JAYANTILAL K. PATEL M.D.)</b>				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-2-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Elkton, Md.</b>	
24. FUNERAL DIRECTOR <b>Ralph E. Hicks</b>		ADDRESS <b>HICKS HOME FOR FUNERALS, ELKTON, MD.</b>		25. DATE RECEIVED BY REGISTRAR AND REGISTRAR'S SIGNATURE <b>JUN 3 1982 James J. Nathan</b>	

BP

*[Faint, illegible handwritten notes]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO. 8 2 1 2 8 8 4									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edward J. Ludwig III</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>05 13 82</b>		2b. HOUR <b>3:16PM</b>	
3. SEX <b>M</b>		4. RACE <b>C</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 24 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PHILA. PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil MD.</b>			
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital of Cecil County</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Postal Service</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't.</b>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>150 E. Main Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Ludwig</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Teeling</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI</b>		17. INFORMANT ADDRESS <b>Marie Ludwig 150 E. Main St. Elkton, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Shock (Hemorrhagic and/or septic)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Post TUR of Carcinoma of Prostate</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>3 hours</b> <b>2 hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Cardiac arrhythmias</b>									
19a. DATE OF OPERATION <b>5/13/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of Prostate with bil. hydronephrosis bladder diverticulum</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/7</b> , 19 <b>82</b> , to <b>5/13</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>5/13</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Eddie S. Saw, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/13/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eddie S. Saw, MD.</b>				22e. ADDRESS <b>135 W. Main Street, Elkton, md 21921</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/17/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Sepulchre Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Philadelphia PA</b>			
24. FUNERAL DIRECTOR NAME <b>Gee Funeral Home 259 E. Main St. Elkton</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 20 1982</b>					
				25b. REGISTRAR'S SIGNATURE <b>James Jan Nathan</b>					

MEDICAL CERTIFICATION

85 1530



154 1530



154 1530



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 20 a 6570 8/30/82 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

1 2

8 8 5

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES CLARK MAGAW</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 22, 1982</b>		2b. HOUR <b>9:50a</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 7, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Perry Point</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center Perry Point, MD</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cab Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Taxi</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Harford</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13d. CITY OR TOWN <b>Aberdeen</b>				13e. STREET ADDRESS <b>17 Liberty Street</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick -- MaGaw</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Rebecca Fawber</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>209-22-2573</b>		17. INFORMANT ADDRESS <b>Bloomsburg, Pa. Mrs. Catherine Beyers, 6450 Main St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE ANTEROSEPTAL MYOCARDIAL INFARCTION</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ALCOHOLIC CIRRHOSIS OF LIVER PERIPHERAL ARTERIOSCLEROTIC VASCULAR DISEASE</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5-20</b> , 19 <b>82</b> , to <b>5-22</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>5-22</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.								
22b. SIGNATURE <b>Klaus H. Huebner</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>May 22, 1982</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KLAUS H. HUEBNER, M.D.</b>				22e. ADDRESS <b>VAMC Perry Point, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 26, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Harford Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md. McComas Funeral Home, Aberdeen, Md.</b>				25a. DATE REC'D BY REGISTRAR <b>MAY 26 1982</b>				

MEDICAL CERTIFICATION

19

BP

[illegible]

106-12-601

5-12

View 1917 1917 1917

**• 0 •**      **-**      **• 1 •**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE													
1- FOR STATE REGISTRAR													
CERTIFICATE OF DEATH													
REG. NO. 8 2 1 2 8 8 6													
1 DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					MONTH DAY YEAR		7b. HOUR	
Charles O. MALLORY					May 23, 1982					1:40AM		1:40 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 74 HRS.	
Male		Black		9 13 1914			67			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U. S. A.					Perry Point, Maryland MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Perry Point, Md.		VA Medical Center						Officer		U.S. Army			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3816 Copley Road Baltimore, Maryland 21215					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
Emory Thurron Mallory					Ianthé L. Clarke								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
YES				215128194		Baltimore, Maryland 21215				Mrs. Lola Mallory Weaver 3816 Copley			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b>													
1629 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 9 1982</b> to <b>May 23 1982</b> , that (I) (we) lost saw the deceased alive on <b>May 23 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE					DEGREE					22c. DATE SIGNED			
					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					5/23/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
Haseeb I Al-Mufti MD					VA Medical Center, Perry Point, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		5/27/82		Arbutus Mem. Park		Baltimore County, Maryland							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Nutter Funeral Homes				3035 W. North Ave. Balto Md. 21216		MAY 27 1982							

8 2 1 2 4 0 0

APR 27 1951

VA Medical Center  
Washington, D.C.  
Dear Sir:  
Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.  
Very truly yours,  
W. A. R. /  
Assistant Secretary  
Department of Veterans Affairs

MAY 13 1951

VA Medical Center, Perry Point, Md.  
3075 N. North Ave.  
Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the container provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 2 8 8 7

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2b. HOUR	
STEPHEN G. MARCIN JR		5-30-82		2:28 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Caucasian	MONTH 07 DAY 28 YE 09	72 years	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Delaware	United States		Cecil		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Elkton	Union Hospital of Cecil County	Teacher	Education		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS		13d. STREET ADDRESS
Maryland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	902 Pickett Lane		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS		
Delaware	New Castle	Newark			
14. FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
Stephen G. Marcin		Anna		Tobias	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		193-16-8227		Helen G. Marcin	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY.)		19. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4254		Coronary Arteriosclerosis Heart Failure, myocardial		14-16 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Cardiac myopathy			
		(c)			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 17, 1976, to July 30, 1982, that (I) (we) last saw the deceased alive on July 29, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Victor M. Magalong, M.D.		M.D.		05-30-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
VICTOR M. MAGALONG, M.D.		325 EAST MAIN STREET, NEWARK, DE.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6-2-82		All Saints Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
William J. Marwick		Newark, Del.		JUN 4 1982 Thomas J. Marwick	

BP

1588



State  
Commission  
70  
28  
09  
1937

United States  
Union Hospital of Cecil County

Bellevue  
Bellevue  
Bellevue

1937-10-22



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 1 2 8 8 8	
FOR 1. STATE REGISTRAR			CERTIFICATE OF DEATH			REG. NO.
1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy M. Marcus</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 26, 1982</i>		2b. HOUR <i>9:05 PM</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan 3, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>355 Blair Shore Rd.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Cecil</i> 13c. CITY OR TOWN <i>Elkton</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>355 Blair Shore Rd.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Walter Blaiz</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>William Marcus Jr. 365 Blaiz Shore Rd elkton</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Rectum</i> <i>1541</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 Months</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>none</i>						
19a. DATE OF OPERATION <i>March 18, 81</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>carcinoma of Rectum</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>March 15, 1981</i> to <i>May 11, 1982</i> , that (I) (we) last saw the deceased alive on <i>May 11, 1982</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Robert A. Menaker MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5-26-82</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert A. Menaker MD</i>				22e. ADDRESS <i>132 W. Main St. Newark Del.</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-29-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gilpin Manor Mem Pk</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Elkton Cecil Md.</i>
24. FUNERAL DIRECTOR NAME <i>Charles McKelvey</i>				25a. RECEIVED BY REGISTRAR <i>John I. 1982</i>		25b. RECEIVED BY REGISTRAR <i>Cecil McKelvey</i>
Gee Funeral Home 259 E. Main St. Elkton, Md.						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be filed at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 2 8 8 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Charles Stanley Moore				2a. DATE OF DEATH MONTH DAY YEAR May 23, 1982			
2b. HOUR 7:15 P.M.							
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 04, 1994		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Providence Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. STATE Md		13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Moore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Scarborough		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO 217 36 4242		17. INFORMANT Charles Moore		ADDRESS Elkton, Md. 21921 2754 Telegraph Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure.</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>gastrointestinal bleeding, pneumonia renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerotic-vascular disease.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>5/18</u> 19 <u>82</u> , to <u>5/23</u> 19 <u>82</u> , that (1) (we) lost saw the deceased above, (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Jui Chih Hsu</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/26/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui Chih Hsu MD		22e. ADDRESS 223 west main st. Elkton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-27-82		23c. NAME OF CEMETERY OR CREMATORY SHARPS Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE FAIR HILL Cecil MD.	
24. FUNERAL DIRECTOR NAME Richard L. Goodie Rising Sun, Md.		ADDRESS		25a. DATE REGD. BY REGISTRAR JUN 2 1982		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	

U.S. 1500



U.S. 1500

U.S. 1500

U.S. 1500

U.S. 1500

U.S. 1500

U.S. 1500

U.S. 1500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

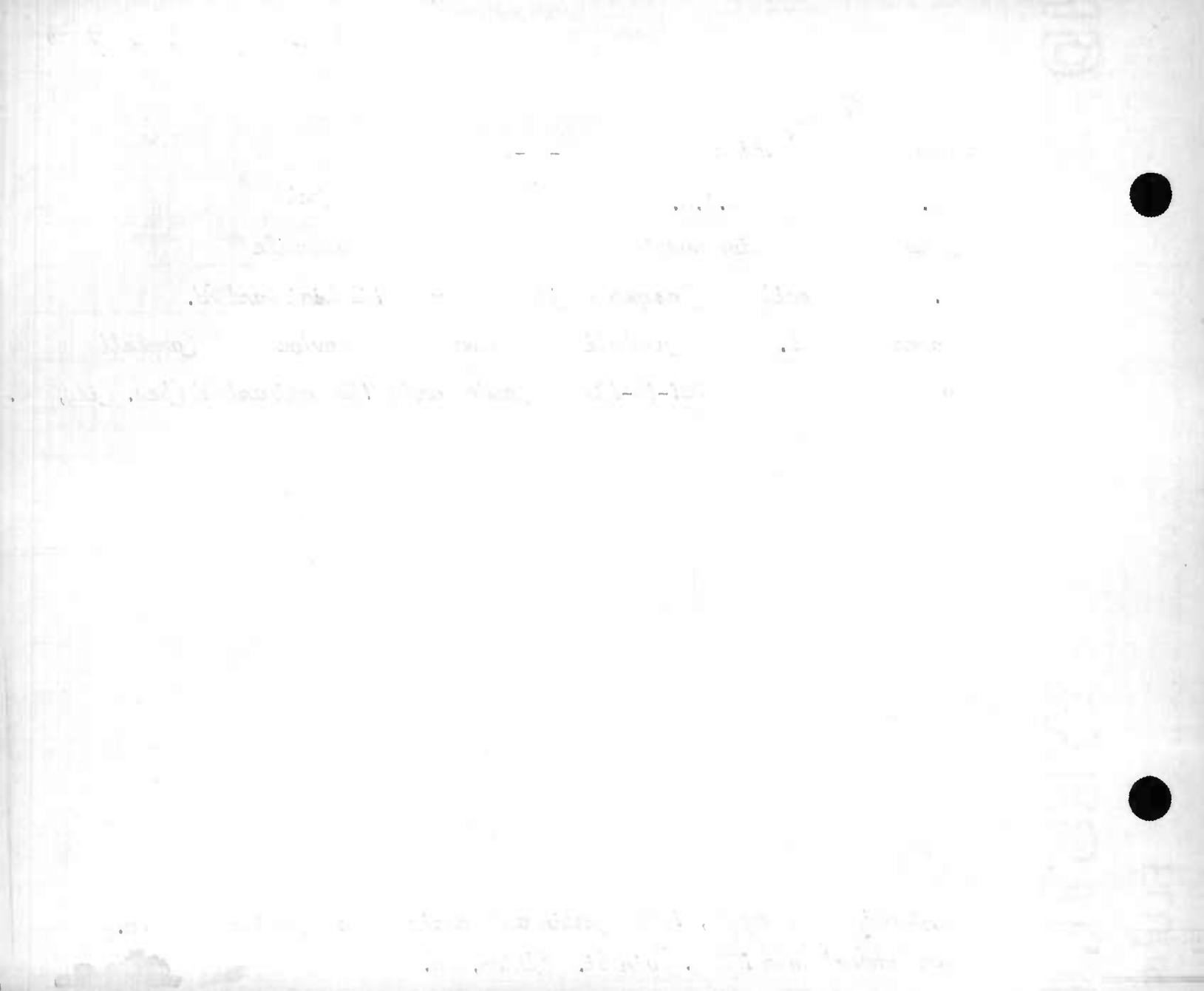
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 2 8 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>MARY C MURPHY</i>		2a. DATE OF DEATH MONTH <i>5</i> DAY <i>24</i> YEAR <i>1982</i>		2b. HOUR <i>3:45</i> <sup>M</sup>	
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH <i>5</i> DAY <i>26</i> YEAR <i>1928</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>54</i> YRS.		7. UNDER 1 YEAR MONTHS <i>54</i> DAYS <i>54</i>		8. UNDER 24 HRS HOURS <i>54</i> MIN. <i>54</i>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> <sup>MD.</sup>	
12. CITY OR TOWN OF DEATH <i>Elkton</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE <i>Md.</i> 15b. COUNTY <i>Cecil</i> 15c. CITY OR TOWN <i>Chesapeake City</i>		16. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		17. STREET ADDRESS <i>152 Boat Yard Rd.</i>	
18. FATHER'S NAME FIRST <i>Homer</i> MIDDLE <i>L.</i> LAST <i>Campbell</i>		19. MOTHER'S MAIDEN NAME FIRST <i>Anna</i> MIDDLE <i>Hevlow</i> LAST <i>Campbell</i>			
20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		20b. SOCIAL SECURITY NO. <i>221-18-1368</i>		20c. INFORMANT <i>Claude Murphy</i> ADDRESS <i>152 Boatyard Rd Ches. City, Md.</i>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>METASTATIC Cancer of LUNG.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <i>5-23-82</i> , 19 <i>82</i> , to <i>5-24</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>5-23</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <i>Jo Ann Rosenfeld, MD.</i>		22b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/24/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jo Ann Rosenfeld</i>		22e. ADDRESS <i>Cecilton Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>May 25, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cratin and Fennell West Chester, Ohio</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. NAME AND ADDRESS OF FUNERAL HOME <i>Joe Funeral Home 259 E. Main St. Elkton, Md.</i>			

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pogelid may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an order for medical examination must be obtained.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Stanley A MYERS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 31, 1982</b>			2b. HOUR <b>10:45A M</b>			
1. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 5 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil Co. MD.</b>			
11. CITY OR TOWN OF DEATH <b>Perry Point, Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER</b>				12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) <b>Plumer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home Repair</b>	
13a. STATE <b>Md</b>		13b. COUNTY <input checked="" type="checkbox"/>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2907 ALVARDO Sq</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM Myers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Mueller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1923-1929</b>		17. INFORMANT <b>FAMILY</b>		ADDRESS <b>Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremic and Severe Anemia</b> <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congested Heart Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Persistent Pneumonia</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 14</b> , 19 <b>76</b> , to <b>May 31</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>May 31</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jean-Pierre P. Jacques</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>5/31/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEAN-PIERRE, P. Jacques</b>				22e. ADDRESS <b>VA Medical Center, Perry Point, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/2/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO Md</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Evans Funeral Home, Baltimore, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 7 1982</b>					

MEDICAL CERTIFICATION

Evans Funeral Home, Baltimore, Md.

Burial 6/21/82 Woodlawn

Edie

LEA-THURMAN, P. Jacques

VA Medical Center, Perry Point, Md

2/21/81

May 21

82

Dec 14

76

May 21

82

Potential Pneumonia

Concomitant Heart Disease

Recent History

Uteric and Severe Anemia

Yes not very serious

William

Myers

Levine

Family Records

MD

Edie

x

2401 HARRIS

2

Perry Point, Md

VA Medical Center

Plummer

and Myers

MD

W. R.

Cecil Co

77

1972

White

Gender

Age

May 21, 1982

10:45A

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 8 9 2

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH DAY YEAR		4. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH		3. MONTH DAY YEAR		4. HOUR	
John Baian Nickle		5. 17 19 82		6. 5 17 19 82		7. 11:28 a. M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 24 HRS.	8. DATE PRONOUNCED DEAD	9. MONTH DAY YEAR	10. HOUR
Male	White	Nov. 21, 1968	13 YRS.		5	18	19 82
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	12. CITIZEN OF WHAT COUNTRY?	13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		14. BALTIMORE CITY OR COUNTY OF DEATH			
Elkton, Md.	U.S.A.			Cecil County, MD.			
15. CITY OR TOWN OF DEATH	16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		18. KIND OF BUSINESS OR INDUSTRY		
Elkton	Union Hospital of Cecil County		Student				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
19a. STATE	19b. COUNTY	19c. CITY OR TOWN	19d. INSIDE CITY LIMITS?	19e. STREET ADDRESS			
Md.	Cecil	Elkton	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	2250 E. Old Philadelphia Rd.			
20. FATHER'S NAME		21. MOTHER'S MAIDEN NAME		22. ADDRESS			
John R. Nickle		Janet S. Blackburn		John R. Nickle 2250 E. Old Phila. Rd.			
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		23. SOCIAL SECURITY NO.		24. INFORMANT			
No				John R. Nickle 2250 E. Old Phila. Rd.			
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I DEATH WAS CAUSED BY:							
9258 IMMEDIATE CAUSE (a) Electrocution							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
26. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED?		27. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
28. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		28. TIME OF INJURY (est.)		29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		? P.M. 5 17 19 82		subject touched electrical lines			
30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		30. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		31. LOCATION			
		platform		W. Main St. north of Rt. 40, Elkton, Cecil Co., Md.			
32. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
33. ACTUAL SIGNATURE		33. TITLE (SPECIFY)		33. DATE SIGNED		33. MEDICAL EXAMINER	
Virginia L. Dolan		M.D. Assistant		5-18-82			
34. EXAMINER'S NAME (TYPE OR PRINT)		34. ADDRESS		34. DATE REC'D. BY REGISTRAR			
Virginia L. Dolan, M.D.		111 Penn Street		MAY 24 1982			
35. BURIAL, CREMATION, REMOVAL (SPECIFY)		35. DATE		35. NAME OF CEMETERY OR CREMATORY		35. LOCATION	
Burial		5/21/82		Cherry Hill R.C. Cemetery		Elkton, Cecil Co., Md.	
36. FUNERAL DIRECTOR		36. DATE REC'D. BY REGISTRAR		36. REGISTRAR		36. SIGNATURE	
Gee Funeral Home		259 E. Main St. Elkton, Md.		MAY 24 1982		Name	

1891

Nov. 25, 1891

Dear Sir,

I have

received

your

letter

of the

25th

inst.

and

in

reply

to

you

will

find

that

I

am

very

truly

Yours

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR - STATE REGISTRAR		8 2 1 2 8 9 3 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN J. REEB Sr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>5-16-82</b>		2b. HOUR <b>12:25 P</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 17 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County, Md.</b>			
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hosp.-Elkton, Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Factory Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3901 Coolidge Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>212-18-3095A</b>		17. INFORMANT <b>415 Biddle St. John J. Reeb, Jr. Chesapeake, Md. 21915</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAL ARREST</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>MYOCARDIAL INFARCTION</b> (c) <b>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED <b>N/A</b> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 16</b> , 19 <b>82</b> , to <b>May 16</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>May 16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Marianne Friedberg MD</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>5/16/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARIANNE FRIEDBERG MD</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-19-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>G.T. Schwab, P.A.</b>				3512 Frederick Ave. #21229		25a. DATE RECEIVED BY REGISTRAR'S SIGNATURE <b>MAY 21 1982</b>			
				25b. REGISTRAR'S SIGNATURE <b>James San Nathan</b>					

8 3 1 2 3 3 0



Rate 16 02  
White  
No. 1000  
Union National Bank, 1000  
1000 Coolidge Ave.

212-10-3000  
John L. Thompson, Jr.  
212-10-3000

... and, 4. 4 212 212 212 212 212  
212-10-3000  
John L. Thompson, Jr.  
212-10-3000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 1 2 8 9 4 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>George Rhoades</b>		2a. DATE OF DEATH <b>May 25, 1982</b>		2b. HOUR <b>5:35</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Dec. 15, 1908</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Del.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>		
10. CITY OR TOWN OF DEATH <b>Elkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Equip. Opr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State Road</b>
13a. STATE <b>MD.</b>		13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Elkton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>375 Hollingsworth Manor</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Rhoades</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine McMunn</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>091-07-8703</b>		17. INFORMANT ADDRESS <b>Florence V. Rhoades Elkton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute respiratory failure.</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic ca.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD. Diabetic mellitus.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <b>4/7</b> 19 <b>78</b> to <b>5/24</b> 19 <b>82</b> , that (b) (we) lost saw the deceased alive on <b>5/24</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Jui-Chin Hsu</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>5-27-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jui-Chin Hsu</b>		22e. ADDRESS <b>223 W. Main St. Elkton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5-28-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>North East Cecil Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>5/21 1982</b>	
24. FUNERAL DIRECTOR NAME <b>Paul R. Couch</b>		ADDRESS <b>North East, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

BP

8 1 5 1 9 1

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

8 1 5 1 9 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

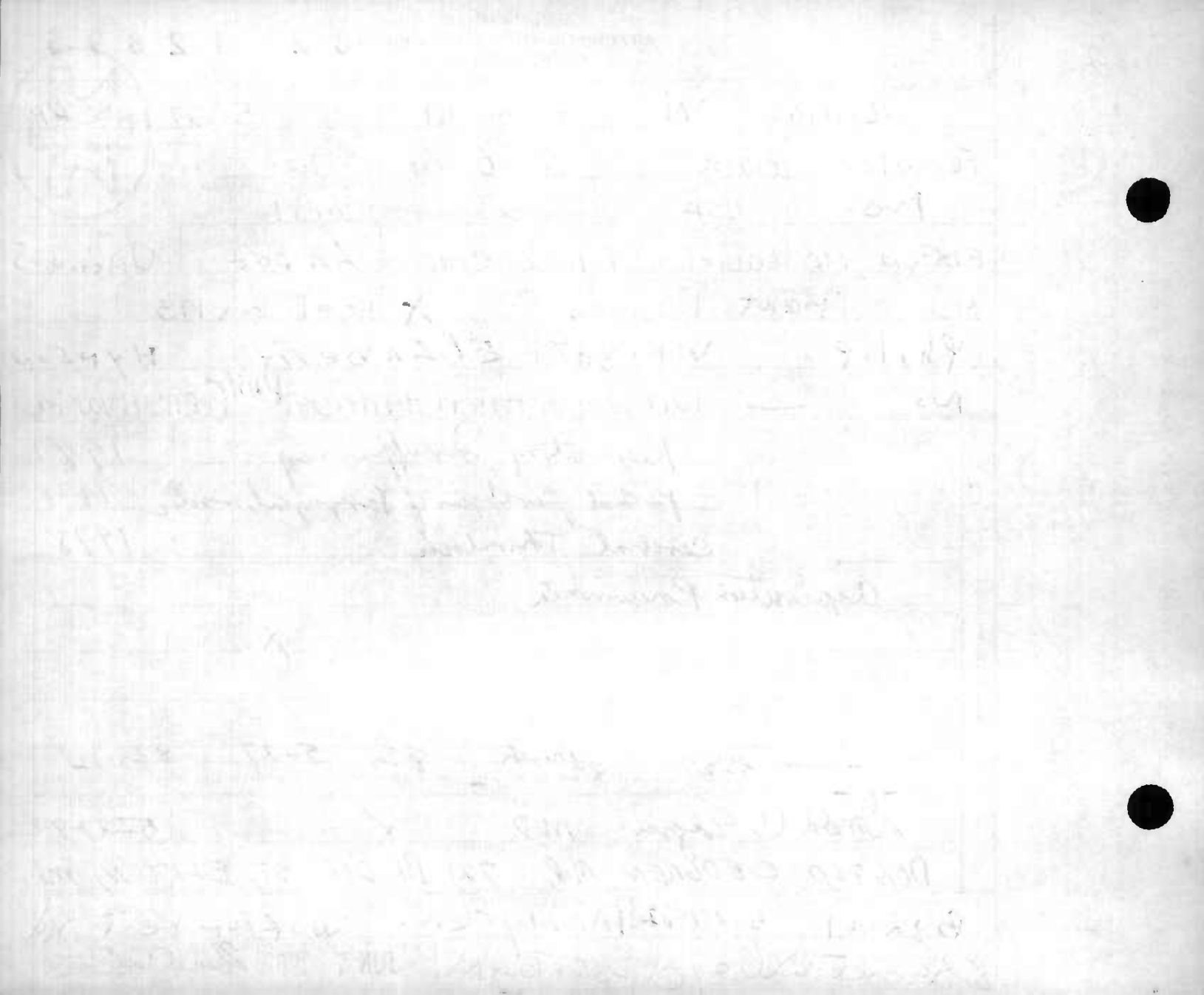
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	2	8	9	5
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian W Ringgold										2a. DATE OF DEATH MONTH DAY YEAR 5 27 82				2b. HOUR 5:40 P.M.		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 6 06		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.										
10. CITY OR TOWN OF DEATH ELKTON, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurelwood Nrsng. Cntr.				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) LABOR			12b. KIND OF BUSINESS OR INDUSTRY VARIOUS							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY Kent		13c. CITY OR TOWN Worton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #1 Box 173						
14. FATHER'S NAME FIRST MIDDLE LAST Ph. I. P. W. R. 3d7				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hynson												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 217-12-4799		17. INFORMANT Harold Henderson Pennsylvania										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Partial paralysis of laryngeal muscles DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Thrombosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1982 1978 1978						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Aspiration Pneumonia																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from March 1982 to 5-27 1982, that (I) (we) lost saw the deceased alive on 5-27 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Donald C. Edgren M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-27-82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD C. EDGREN M.D.				22e. ADDRESS 721 BRIDGE ST., ELKTON, MD.												
23a. BURIAL, CREMATION, REMOVAL (SEE IF 1) BURIAL				23b. DATE 6-2-1982		23c. NAME OF CEMETERY OR CREMATORY Fam. ly Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Worton Kent MD								
24. FUNERAL DIRECTOR NAME Benjamin W. O'Connell				ADDRESS Chester Town		25a. DATE REC'D. BY REGISTRAR JUN 7 1982		25b. REGISTRAR'S SIGNATURE Thomas J. ...								

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 2 8 9 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANDREW</b> <b>SAWICKI</b>			2a. DATE OF DEATH MONTH <b>5</b> DAY <b>3</b> YEAR <b>1982</b>		2b. HOUR <b>340</b> P.M.
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>30</b> YEAR <b>1987</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.	7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL</b> MD.	
10. CITY OR TOWN OF DEATH <b>ELKTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LH 101N</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FACTORY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>
13a. STATE <b>MD</b>			13b. COUNTY <b>CECIL</b>	13c. CITY OR TOWN <b>ELKTON</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>SAWICKI</b> LAST <b>SAWICKI</b>			15. MOTHER'S MAIDEN NAME FIRST <b>ANN</b> MIDDLE <b>SAWICKI</b> LAST <b>SAWICKI</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>198 05 1642</b>		17. INFORMANT ADDRESS <b>CITY MD</b> <b>TENNIE GREEN CHESAPEAKE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic Shock -</b> <b>1619</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Status Post-op Carcinoma of Larynx</b> (c) <b>Electrolyte Imbalance ASHED</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jayantilal Patel MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>5/5/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAYANTILAL PATEL MD</b>		22e. ADDRESS <b>123 Sincerely Ave Elkton MD</b>			
23a. BURIAL, CREMATION, REMOVAL (COPY) <b>BURIAL</b>		23b. DATE <b>5-6-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ROSE OF LIMA</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>CHESAPEAKE CITY CECIL MD</b>		24. FUNERAL DIRECTOR NAME <b>RIT. FORD FUNERAL HOME</b> ADDRESS <b>CHESAPEAKE</b>			
25a. DATE REC'D. BY REGISTRAR <b>MAY 10 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO. 8 2 1 2 8 9 7						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William A. Shelton</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>5/19/82</i>			2b. HOUR <i>1116 P</i>			
3. SEX <i>White Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 2 09</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.		7. UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		8b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.					
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Agri.</i>			
13a. STATE <i>Md.</i>					13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Rising Sun</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert D. Shelton</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna V. Brown</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>222-01-0892</i>		17. INFORMANT ADDRESS <i>Leonard Lochart Rising Sun Md.</i>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Cerebrovascular disease</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Edgar E. Folck</i>						DEGREE <i>MD.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/21/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edgar E. Folck MD.</i>						22e. ADDRESS <i>ELKTON, MD 21921</i>					
23a. BURIAL, CREMATION, REMOVAL <i>Cremation</i>			23b. DATE <i>5-25-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cratin and Ferris</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>West Chester Pa.</i>			
24. FUNERAL DIRECTOR <i>Geer Funeral Home</i>						25a. DATE REC'D. BY REGISTRAR <i>MAY 24 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>			

BP

15897

Section 10  
Section 11  
Section 12  
Section 13  
Section 14  
Section 15  
Section 16  
Section 17  
Section 18  
Section 19  
Section 20  
Section 21  
Section 22  
Section 23  
Section 24  
Section 25  
Section 26  
Section 27  
Section 28  
Section 29  
Section 30  
Section 31  
Section 32  
Section 33  
Section 34  
Section 35  
Section 36  
Section 37  
Section 38  
Section 39  
Section 40  
Section 41  
Section 42  
Section 43  
Section 44  
Section 45  
Section 46  
Section 47  
Section 48  
Section 49  
Section 50  
Section 51  
Section 52  
Section 53  
Section 54  
Section 55  
Section 56  
Section 57  
Section 58  
Section 59  
Section 60  
Section 61  
Section 62  
Section 63  
Section 64  
Section 65  
Section 66  
Section 67  
Section 68  
Section 69  
Section 70  
Section 71  
Section 72  
Section 73  
Section 74  
Section 75  
Section 76  
Section 77  
Section 78  
Section 79  
Section 80  
Section 81  
Section 82  
Section 83  
Section 84  
Section 85  
Section 86  
Section 87  
Section 88  
Section 89  
Section 90  
Section 91  
Section 92  
Section 93  
Section 94  
Section 95  
Section 96  
Section 97  
Section 98  
Section 99  
Section 100

Section 101  
Section 102  
Section 103  
Section 104  
Section 105  
Section 106  
Section 107  
Section 108  
Section 109  
Section 110  
Section 111  
Section 112  
Section 113  
Section 114  
Section 115  
Section 116  
Section 117  
Section 118  
Section 119  
Section 120  
Section 121  
Section 122  
Section 123  
Section 124  
Section 125  
Section 126  
Section 127  
Section 128  
Section 129  
Section 130  
Section 131  
Section 132  
Section 133  
Section 134  
Section 135  
Section 136  
Section 137  
Section 138  
Section 139  
Section 140  
Section 141  
Section 142  
Section 143  
Section 144  
Section 145  
Section 146  
Section 147  
Section 148  
Section 149  
Section 150  
Section 151  
Section 152  
Section 153  
Section 154  
Section 155  
Section 156  
Section 157  
Section 158  
Section 159  
Section 160  
Section 161  
Section 162  
Section 163  
Section 164  
Section 165  
Section 166  
Section 167  
Section 168  
Section 169  
Section 170  
Section 171  
Section 172  
Section 173  
Section 174  
Section 175  
Section 176  
Section 177  
Section 178  
Section 179  
Section 180  
Section 181  
Section 182  
Section 183  
Section 184  
Section 185  
Section 186  
Section 187  
Section 188  
Section 189  
Section 190  
Section 191  
Section 192  
Section 193  
Section 194  
Section 195  
Section 196  
Section 197  
Section 198  
Section 199  
Section 200

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
RICHARD		JOSEPH		SPILLANE				May 14, 1982		12:10pm	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
Male		White		7 15 1914		67					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		USA				Cecil					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Perry Point, Md.		VA Medical Center		Machinist		Army/Civilian					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Harford		Havre de Grace				202 North Washington Street			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John		Spillane		Mary		McKinney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		WW-II		072-07-6878		VAMC Records, Perry Point, Md. 21902					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Anemia DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4860										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from November 18, 19 80, to May 14, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Julian Ocejjo M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-14-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN OCEJO, M.D.						22e. ADDRESS VA Medical Center, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		18 May 82		Culpeper National		Culpeper Culpeper Virginia					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR MAY 18 1982					
Tarring Funeral Home, Aberdeen, Md. 21001-3399											

12:10 PM  
 MAY 14, 1962  
 SOUTH  
 JOHN  
 RICHARD  
 100  
 11-11  
 072-07-6878  
 JOHN  
 GILLIAN  
 202 NORTH WASHINGTON BLVD  
 PERRY POINT, MD. 21902  
 RESPIRATORY FAILURE  
 CURRENT PRESENTS

XXXXXXXXXXXXXXXXXXXXXXXX  
 X  
 11-11  
 072-07-6878  
 JOHN  
 GILLIAN  
 202 NORTH WASHINGTON BLVD  
 PERRY POINT, MD. 21902  
 RESPIRATORY FAILURE  
 CURRENT PRESENTS

1- FOR  
STATE  
REGISTRAR

6-25-82 AL

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 2 1 2 8 9 9

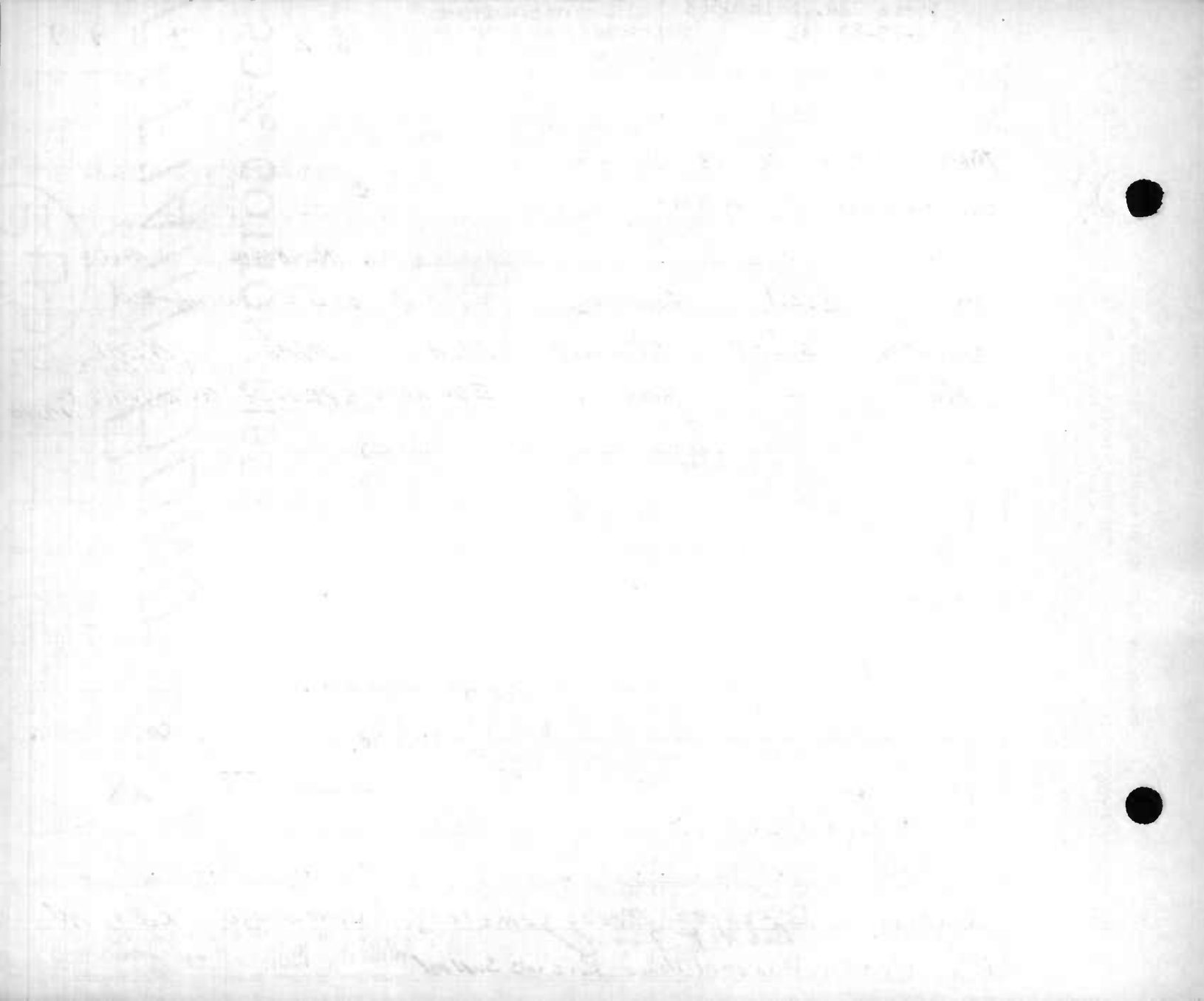
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF ESTI- DEATH MATED			7b. HOUR		
MARSHALL L. SPROUSE			5 20 19 82			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
MALE	WHITE	8 18 53	28 YRS.	MONTHS	DAYS	5 21 19 82	5:35 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
OREGON, U.S.A.		U.S.A.				Cecil County MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Conowingo		East of Rt. 222 on Old Conowingo Rd.				MECHANIC		Auto
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Md.			CECIL	CONOWINGO	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	OLD CONOWING RD.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
EDWARD SCOTT SPROUSE			ELLA MAE NEAL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			UNKNOWN			P.O. Box 222 EDWARD SPROUSE QUARRYVILLE, PA.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Gunshot wound to head (rifle)								
9652								
DUE TO, OR AS A CONSEQUENCE OF								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
			? P.M. 5-20-19 82		Subject found shot.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			road		East of Rt. 222 on, Conowingo, Cecil Md. Old Conowingo Rd.			
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE			TITLE (SPECIFY)				DATE SIGNED	
Ann M. Dixon, M.D.			M.D. Assistant MEDICAL EXAMINER				5-22-82	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Ann M. Dixon, M.D.			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			5-25-82		MARRS CEMETERY		CONOWINGO CECIL MD.	
24. FUNERAL DIRECTOR NAME			24b. ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
R.T. FOARD FUNERAL HOME			Rising Sun, Md.		JUN 2 1982		Ann M. Dixon	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 12900			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sudie McManus Stevens												2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 20 82		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 29 09		6. AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 20 82		2d. HOUR 4.45 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 601 Maryland Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Domestic			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE MD		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 601 Maryland Avenue							
14. FATHER'S NAME FIRST MIDDLE LAST Samuel McManus						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roxanna Broom									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 243-14-4119		17. INFORMANT Ray Stevens				ADDRESS 1801 Bollinger Rd, Westminster					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5789 IMMEDIATE CAUSE (a) Acute upper gastrointestinal hemorrhage Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE [Signature]						TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 5/20/82					
EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vital, MD						ADDRESS Union Hospital, Elkton, MD 21921									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 24, 1982		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md.					
24. FUNERAL DIRECTOR NAME Gee Funeral Home						25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE [Signature]							

MEDICAL CERTIFICATION



**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						8 2 1 2 9 0 1	
CERTIFICATE OF DEATH						REG. NO.	
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	
						May 20, 1982	
3 SEX			4. RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Male			White	Jun 24 1894		87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		9 BALTIMORE CITY OR COUNTY OF DEATH		
Louisiana			USA		Cecil County MD		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Perry Point, Md.			VA Medical Center				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Virginia			None		YES [X] NO [ ]		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS		
Charles Thomas			Frances Catalino		1838 Diagonal Road		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		
Yes WW I			147-09-7050		Katherine Smith 120 S. Ingram St., Alex., Va.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>4289</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac failure</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
<u>Mild gastric bleed, Senile dementia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES [ ] NO [X]		YES [ ] NO [ ]	
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that X (this hospital) attended the deceased from March 29 19 82 to May 20 19 82 xxxxxxxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two (two) did not sign the body after death)							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
						5-20-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
ABDUL KARIM, M.D.				VA Medical Center, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		5/24/82		St Mary's Cem.		Alexandria, Va.	
24 FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D BY REGISTRAR REGISTRAR'S SIGNATURE			
Walter J. Holt Cunningham Funeral Home, Alexandria, VA.				MAY 26 1982			

2:52pm May 20, 1982

Perry Point, Md. VA Medical Center

147-02-7020

Respiratory arrest

Diffuse pneumonia

Cardiac failure

Mild gastric bleed. Small amount

X

xxxxxx 00 May 20 82

X

xxxxxxxxxxxxxxxxxxxxxxxxxxxx

xx 5-20-82

ABDUL KARIM, H.D. VA Medical Center, Perry Point, Md.

Cunningham Funeral Home, Alexandria, VA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 2 9 0 2									
1. FOR STATE REGISTRAR		REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR			
Samuel Herbert Vill						5/20/82										7:40pm			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Male		White		Feb. 18 1933		49				MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Pennsylvania		USA				Elkton Cecil												MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Elkton		Union Hospital of Cecil County								Sales Manager				Tires					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS											
13a. STATE		13a. COUNTY		13a. CITY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1207 Cotswold La.											
MD N.J.		USA		Elkton				-209 Caspars Way											
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST									
		Henry		Vill				Rose		Deitch									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
yes		Korean		160-26-2081		Roberta Vill		1207 Cotswold La.		Cherry Hill, N.J.									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEVERAL</u> MONTHS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED <input checked="" type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <u>5/20/82</u> to <u>5/20/82</u> , that (I) (we) lost saw the deceased alive on <u>5/20/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death		22b. SIGNATURE <u>DR. SINGH MD.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/20/82</u>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. SINGH MD.</u>		22e. ADDRESS <u>UNION HOSPITAL, ELKTON, MD 21821</u>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		5-23-82		Crescent Burial Ph.		Pennsauken Camden N.J.													
24. FUNERAL DIRECTOR (NAME)		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Paul A. Crouch		North East, Md.		MAY 24 1982		[Signature]													

MEDICAL CERTIFICATION

211

205

1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be certified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8. 2 1 2 9 0 3 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Isaac H. William</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>May 23, 1982</b>				2b. HOUR <b>4:00P M</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 8 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>disabled</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Havre de Grace</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>571 Otsego St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joshua Williams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Carey</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes 10-42 11-45</b>				16b. SOCIAL SECURITY NO. <b>717 09 5856</b>		17. INFORMANT ADDRESS <b>VAMC, Perry Point, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4409</b> IMMEDIATE CAUSE (a) <b>Chronic renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced arteriosclerotic vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5-11-</b> 19 <b>82</b> to <b>5-23-</b> 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>5-23-</b> 19 <b>82</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death.									
22b. SIGNATURE <b>Haseeb I. Al-Mufti, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>5-23-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HASEEB I. AL-MUFTI, M.D.</b>				22e. ADDRESS <b>VAMC, Perry Point, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-29-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>United Methodist</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aberdeen Harford Md</b>			
24. FUNERAL DIRECTOR <b>ARNOLD W. BEARD, Funeral Service</b>				353 Fountain St., Havre de Grace, Md.		25a. DATE REC'D. BY REGISTRAR <b>MAY 25 1982</b>			
				25b. REGISTRAR'S SIGNATURE <b>James J. Fisher</b>					

8 2 3

Jan 22, 1902

James H. Wilson

Army Medical Center

10-11-11

Chronic renal failure

Advanced arteriosclerosis vascular & chronic

Ward, Perry Point, Md

Ward, Perry Point, Md  
301 Franklin St.  
Ward, Perry Point, Md